TENNESSEE STATE PROFILE

A. Program Description

Overview

TennCare, Tennessee's Medicaid program, is a statewide, mandatory managed care program that serves the state's entire Medicaid population. In 2007, Tennessee began integrating behavioral health services into its managed care contracts; these services were previously carved out and managed by a separate behavioral health organization (BHO). In 2010, the state rolled long-term care services and supports into its managed care contracts for certain beneficiaries as part of the state's CHOICES program.[1] Three managed care organizations (MCOs) currently are responsible for managing a range of services for more than 1.2 million beneficiaries across the state.

Financing

Since 2002, TennCare has operated under an 1115 demonstration waiver, now called TennCare II, which the Centers for Medicare and Medicaid Services recently extended; it now expires in 2016. MCOs are in an at-risk situation for beneficiaries' physical health, behavioral health, and long-term care services. Four plans currently are available to TennCare beneficiaries: UnitedHealthcare, Amerigroup, and BlueCare are available in certain regions of the state. TennCare Select, a partial-risk prepaid inpatient health plan administered by BlueCare, is also available to beneficiaries who meet additional financial and needs-based eligibility criteria.

Goals

The TennCare II demonstration aims to use managed care to provide an integrated package of acute and long-term care services at a cost that does not exceed what would have been spent in a Medicaid fee-for-service program. It also endeavors to ensure access and quality care to enrollees, and provide appropriate and cost-effective home and community-based services that will improve the quality of life for eligible beneficiaries.

Context

The state recently completed an MCO rebid process; the three incumbent MCOs will retain contracts in 2015. However, the distribution of beneficiaries among the three organizations, which currently varies by region, will be evenly divided across the three

[1] Tennessee's CHOICES program includes nursing facility services and home and community-based services for adults 21 years of age and older with a physical disability, and seniors (age 65 and older).

organizations, and all three plans will be available statewide. State officials also do not intend to expand Medicaid eligibility at this time.

Partnership Structure

The Bureau of TennCare (the Bureau) is the state agency responsible for the management and administration of the TennCare program. The state's Department of Mental Health and Substance Abuse Services (DMHSAS), formerly responsible for oversight of Medicaid behavioral health services in the state, maintains a memorandum of understanding with the Bureau of TennCare. The department staffs meet monthly and quarterly to share information and collaborate around specific initiatives. The Bureau also maintains partnerships with other state agencies, such as the Department of Intellectual and Developmental Disabilities, and Department of Child and Family Services.

At the provider level, behavioral health providers (including community mental health centers [CMHCs]) that serve Medicaid beneficiaries have formal contractual relationships with the MCOs operating in their region. The MCOs provide opportunities for open communication, both formal and informal, with contracted CMHCs and other behavioral health providers through, for example, MCO advisory board meetings and provider relations specialists.

One provider described the partnership model in the state as "triangular"; the Bureau and MCOs communicate, and MCOs and providers communicate. This is consistent with what we heard from other providers we interviewed: they did not have much direct interaction with the Bureau, except through MCO advisory meetings.

B. Coordination or Integration with Physical Health

Coordination Mechanisms and Financing

By bringing management of physical and behavioral health services into one contract and "under one roof," the state hoped to encourage coordination of physical and behavioral health services at both the state administrative and MCO levels. The state has urged MCOs to integrate their data systems so that their staffs can access both physical and behavioral health information and see the "whole picture" of a beneficiary; MCOs have also integrated physical and behavioral health staff to varying degrees. In addition, MCOs provide case management services at the plan level to individuals with complex health needs--such as comorbid physical and behavioral health disorders--through required Population Health Programs, but typically only to high service utilizers and for a brief time. Among the MCO case management services offered are comprehensive health risk assessments, assistance in making and keeping needed medical and or behavioral health appointments, and health coaching. Integration is intended to encourage coordination at all levels; however, state officials, managed care representatives, and providers indicated that the state is operating on a

case management model that shifts the bulk of service coordination efforts for TennCare beneficiaries with behavioral health disorders to the CMHCs through the Medicaid mental health case management (MHCM) benefit included in the MCO benefit package.

Coordinated Services and Interactions

Case managers located at CMHCs and other providers provide MHCM. Beneficiaries must meet medical necessity requirements to receive case management services, and these services generally are unrestricted if they meet continued medical necessity. The state's Medicaid plan offers multiple levels of case management based on need. One level of MHCM benefit allows for provision of team-based approaches, such as Assertive Community Treatment or Continuous Treatment Team services, to beneficiaries with the greatest needs. All MCHM case managers are required to assess beneficiaries' needs so as to refer and coordinate services that will improve functioning and/or maintain stability, which may include coordinating with clients' primary care physicians and other providers of physical health care. Providers mentioned that case managers often facilitate beneficiaries' physical health care by helping clients navigate appropriate provider networks, access services, and interpret information provided by primary care and specialty providers.

In addition to MHCM, the CHOICES program assigns a care coordinator to all TennCare beneficiaries enrolled in its program. This coordinator conducts a health assessment that includes behavioral health and provides referrals to needed services and programs. The care coordinator follows up with the member at least quarterly to ensure that his or her needs are being met. Although multiple-MCO care management staff may be involved in a CHOICES member's care, the beneficiary's CHOICES care coordinator has primary responsibility for coordination of all care needs.

State officials and managed care representatives also mentioned that the integrated arrangement was intended to and has opened the door for conversations between MCOs and providers about coordination of physical and behavioral health services through various models at the provider level. For example, one provider we visited integrated a nurse practitioner into the agency to provide clients with primary care services and has worked with MCOs to better coordinate billing systems for integrated care. Providers in other regions are undertaking similar efforts.

C. Coordination or Integration with Housing or Other Social Services

The TennCare supported housing benefit covers supervised group housing facilities staffed by mental health providers 24 hours a day, seven days a week. Individuals receiving these services must meet medical necessity and level of care standards, and require services and supports in a highly structured setting. Medicaid-supported housing services are intended to be relatively temporary and serve as a

bridge for individuals coming from institutions and other restrictive settings into more independent living in the community.

Coordination Mechanism and Financing

The TennCare Medicaid benefit package includes supported housing as a psychiatric rehabilitation service--a service available before the integration of behavioral health services into managed care contracts. Integration of behavioral health benefits into the MCOs' contracts generally was not intended to alter the housing landscape for individuals with behavioral health conditions. Management of TennCare-funded housing support services and other psychiatric rehabilitation services simply was shifted to the MCOs. However, reviewing and enhancing the definition of supported housing was one of the first initiatives upon which the Bureau and MCOs collaborated after integration occurred.

Contracting arrangements for housing and support services vary by provider. MCOs contract with some CMHCs or psychiatric rehabilitation agencies that own and operate housing and support services. Other behavioral health providers subcontract with housing providers that own and operate housing and/or support services. DMHSAS licenses group homes providing supported housing services. TennCare covers the support services provided to supported housing beneficiaries. Beneficiaries themselves generally cover room and board through their Supplemental Security Income (SSI) benefit or other means.

Beyond the Medicaid-supported housing benefit, other housing options that provide varying levels of independence and support are available to both TennCare and non-TennCare beneficiaries with behavioral health disorders. Much of the housing work for individuals with behavioral conditions appears to center on the Creating Homes Initiative (CHI), through which DMHSAS has worked to create and sustain a variety of permanent, supportive housing opportunities for individuals with mental illnesses. Since its inception in 2000, CHI has created more than 11,000 affordable housing opportunities, with support services as needed, for people living with mental illness, including many of the supervised groups homes in which TennCare supportive housing services are provided. Each region of the state has a regional housing coordinator who works with communities to develop affordable housing options. Although there do not appear to be formal mechanisms linking TennCare and CHI, regional housing facilitators work closely with both TennCare-funded CMHCs and housing providers to find or establish housing opportunities for beneficiaries with mental illnesses.

Coordinated Services and Stakeholder Interactions

Case managers at CMHCs may also coordinate housing for TennCare beneficiaries who are not eligible for supported housing and/or can succeed in less restrictive and more independent settings. Other means--such as housing subsidies, SSI benefits, and others--typically cover room, board, and other expenses for these

options, and CMHC case managers or other providers offer support services through state or federal grant funding.

MCOs have partnered with the Bureau and state associations to expand and enhance housing supports for particularly vulnerable populations. UnitedHealthcare, for example, worked with the state to enhance supported housing services that assist individuals with behavioral health conditions and complex medical needs. These individuals were residing in subacute beds in state hospitals due to comorbid medical conditions that existing providers were unable to adequately address in less restrictive settings without enhanced support. UnitedHealthcare worked with providers to add medical support to supported housing services to permit individuals with high medical needs to move into less restrictive settings. As a result of this enhanced support, UnitedHealthcare reports that it was able to move 95 percent of its members who had been residing in subacute facilities to less restrictive levels of care.

D. Key Perceptions and Lessons Learned for Implementing the Care Coordination Strategy

All stakeholders view case management as critical to improving care for individuals with behavioral health disorders. At both provider and consumer levels, a key component for service coordination for individuals with behavioral health conditions is the state's MHCM benefit. Providers and consumer representatives mentioned that case managers coordinate a broad range of health and social services for beneficiaries, and serve as a bridge to the clients' other providers. Consumer representatives said that consumers without access to such services often contact consumer organizations for assistance in navigating service systems. State officials and MCO representatives also recognized the critical role MHCM plays in care for beneficiaries with behavioral health conditions, and are looking at ways to enhance the benefit by increasing focus on quality and outcomes.

Open communication among providers, MCOs, and the Bureau is critical. Providers commented on the importance of communication with MCOs in allowing them to innovate and implement coordination strategies. Provider relations specialists and other provider-specific contacts at MCOs serve as key sources of information and assistance for providers as they attempt to apply service definitions and bill for services. Providers and advocates also cited quarterly provider "problem-solving" meetings with the Bureau as a key indication of the state's willingness to communicate and collaborate. Although providers appreciated the availability and willingness of the state and MCOs to communicate, some mentioned that they sometimes felt like a "little fish in a big pond," since behavioral health services were carved into managed care contracts. They observed that behavioral health providers now are competing with a wide range of other providers for attention from and prioritization by the Bureau and MCOs.

Data can enhance coordination and inform policy decision making. Providers and state associations cited the benefits of using data to drive care and advocate for

system change. One provider, for example, requested to be notified by the MCOs when a patient was admitted to an emergency department so as to tailor care more appropriately. At the association level, the Tennessee Association of Mental Health Organizations has established a data warehouse that member provider organizations populate with data from all client payers. Data from the warehouse have been used in advocacy efforts with MCOs and local legislators.

Provider competition generated by integration of behavioral health services into managed care contracts is both beneficial and challenging. The introduction of multiple MCOs has encouraged competition among provider organizations; in turn, this has encouraged efficiency and innovation at the provider level. Providers now must compete to secure MCO contracts and demonstrate an ability to provide quality care at competitive rates. Although most providers indicated that, on balance, competition among providers has been a positive outcome of the integration of benefits at the plan level, it has also caused a great deal of upheaval. Some providers found it necessary to merge or affiliate to remain competitive in a managed care environment. Some suggested that affiliation occurred to increase the ability to negotiate with and demonstrate service capacity to MCOs. Competition may also have somewhat diminished collaboration between community behavioral health agencies. To describe the current reality of competition and collaboration, one respondent said “We’re all in this together, separately”.

The complexity of contracting with multiple MCOs using different billing systems, service definitions, and financing arrangements presents administrative challenges for providers. Provider and consumer respondents viewed contracting with multiple MCOs as a challenge that has required them to learn and adapt. Providers, for example, mentioned that billing and payment practices vary widely among the MCOs. One provider noted that for case management, one MCO pays a daily rate, one a monthly, and one in 15-minute increments. Providers likewise mentioned ambiguous contract language and the broad service definitions established by the state as a challenge. Whereas providers understand and appreciate the need for flexible language to permit provider and MCO innovation, some also suggested that it is important to strike a balance between giving MCOs enough flexibility to establish service definitions that meet their needs and enough specificity in service guidelines to prevent room for interpretation. Respondents said that billing codes traditionally used by MCOs do not always fully capture the complexities of behavioral health services--particularly team-based services. A distinct and ongoing challenge has been educating MCOs. Providers noted that MCOs might not be as familiar with specialty behavioral health services as would specialty managed BHOs regarding the types and nuances of behavioral health services and ensuring that they establish policies accordingly.

Other state policies and practices should be considered and amended to facilitate provider coordination. Several providers mentioned that challenges associated with same-day billing of physical and mental health services create barriers to service integration, particularly for providers that wish to provide co-located behavioral and physical health services; they strongly recommended that same-day

billing be both permitted and achievable. Tennessee permits same-day billing and, along with MCOs, is working to adjust data and billing systems to accommodate billing for physical and behavioral health services on the same day. Such reengineering has taken time, however. In addition, primary care health codes are not necessarily included in MCO contracts with behavioral health providers, so if the latter would like to administer physical health services, they must participate in additional negotiation with the plan to include the necessary codes.

UNDERSTANDING INNOVATIVE STATE SYSTEMS THAT SUPPORT COORDINATED SERVICES FOR INDIVIDUALS WITH MENTAL AND SUBSTANCE USE DISORDERS

Reports Available

Improving the Coordination of Services for Adults with Mental Health and Substance Use Disorders: Profiles for Four State Medicaid Initiatives

HTML http://aspe.hhs.gov/report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-profiles-four-state-medicaid-initiatives

PDF http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-profiles-four-state-medicaid-initiatives

Illinois Profile only -- http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-illinois-state-profile

Louisiana Profile only -- http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-illinois-state-profile

Massachusetts Profile only -- http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-illinois-state-profile

Tennessee Profile only -- http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-illinois-state-profile

State Strategies for Coordinating Medicaid Services and Housing for Adults with Behavioral Health Conditions

HTML http://aspe.hhs.gov/basic-report/state-strategies-coordinating-medicaid-services-and-housing-adults-behavioral-health-conditions

PDF http://aspe.hhs.gov/pdf-report/state-strategies-coordinating-medicaid-services-and-housing-adults-behavioral-health-conditions

State Strategies for Improving Provider Collaboration and Care Coordination for Medicaid Beneficiaries with Behavioral Health Conditions

HTML http://aspe.hhs.gov/basic-report/state-strategies-improving-provider-collaboration-and-care-coordination-medicaid-beneficiaries-behavioral-health-conditions

PDF http://aspe.hhs.gov/pdf-report/state-strategies-improving-provider-collaboration-and-care-coordination-medicaid-beneficiaries-behavioral-health-conditions